MDR: M4-02-4036-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $1,265.49 for dates of service, 07/19/01 and 08/03/01.

   b. The request was received on 06/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Request for reconsideration, dated 01/28/02
   e. Carrier reconsideration audit dated 02/11/02
   f. Additional documentation requested on 07/12/02, no Requestor response noted in the dispute file.
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   The Respondent did not submit a response to the Provider's request for medical dispute resolution. The "No Carrier Information Found" sheet is reflected in Exhibit II of the Commission's case file.

3. Notice of "No Carrier Sign Sheet" reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Noted on Requestor's Table of Disputes Services

   "Charges reduced by 3% of billed. No established R&C allowance recognized for hospitals. We believe our charges are fair & reasonable and no discount should apply. According to Rule 134.401 (a) Applicability (4) of the Texas Workforce Commission, there are no fee schedules for outpatient treatment at a hospital facility. The payor applied the Medical Fee Guideline rates for physicians. We believe our charges are fair & reasonable and no discount should apply."

2. Respondent: No response found in dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 07/19/01 & 08/03/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $2,357.00 for services rendered on the above dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,091.51 for services rendered on the above dates in dispute.

5. Carrier's EOB denies payment as, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $1,265.49 for services rendered on the dates of service in dispute.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/19/01 08/03/01	72158 255	$2106.00 $251.00	$848.00 $243.51	M M	No MAR No MAR	TWCC Rule 133.304 (c); Acute Care Inpatient Hospital Fee Guidelines Rule 134.401 (a) (3) and (c) (4); Rule 133.307 (g) (3) (D); CPT Descriptor	CPT Code 72158 – MRI of the lumbar back with and without contrast (Revenue Code 255)– was rendered in a hospital radiology department, not a physician's office. Therefore, these Codes are subject to the Acute Care Inpatient Hospital Fee Guidelines (ACIHFG), Rule 133.304, which states radiological services "..shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services." Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider has not submitted any documentation to support this; therefore, no reimbursement is recommended.
Totals		$2357.00	$1091.51				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 6th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt